STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265324	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing Center	100 Woodland Court Arnold, MO 63010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the physician and resident representative of a fall for one resident (Resident #1) out of five sampled residents. The facility census was 122. 1. Review of the facility policy titled, Following a Resident Fall, dated 04/29/25, showed: - The licensed nurse assess the resident for injuries (including neuro checks if indicated) and provides necessary treatment and initiates the Situation, Background, Assessment, Recommendation (SBAR - a structured communication tool used to improve the clarity and efficiency of information exchange between healthcare professionals, especially when reporting a change in a resident's condition); - The physician and resident's representatives are notified; 2. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 03/05/2025, showed: - admitted to facility on 02/21/23; - Cognition impaired; - Diagnoses of dementia (a general term for a decline in mental ability severe enough to interfere with daily life), diabetes (a condition that happens when your blood sugar is too high. It develops when your pancreas doesn't make enough insulin or any at all), chronic kidney disease stage 2 (medical condition where the kidneys stop functioning normally and can no longer filter waste from the blood), and hypertension (high blood pressure); - Delusions (fixed, false beliefs that a person firmly holds despite evidence to the contrary, and they are a symptom of various mental health conditions); - Verbal behaviors directed towards others 4-6 days a week; - Rejection of care 1-3 days a week; Review of Resident #1's Care Plan with interventions, updated on 04/24/24, showed he/she is at risk for falls with interventions to notify physician and responsible party of fall. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's progress notes showed a late entry on 05/09/25 at 4:36 P.M., which said the following: - Nurse was notfied by staff that Resident #1 was seen stuck between his/her bed and the wall; - The bed was moved from the wall and the resdent assessed; - At the time of the assessment the resident's main complaint was being on the floor; - No visible signs of acute injuries at that time; - Resident placed into the bed through the night shift staff; - Resident continued with normal behaviors of calling out, never mentioned any injury from the fall; - No documentation regarding calling the resident's responsible party or doctor. During an interview on 06/03/25 at 3:05 P.M., Certified Nurse Aide (CNA) A said he/she was in Resident #1's room providing incontinent care on 05/08/25. CNA A turned to wet a washcloth, and heard the resident scream. CNA A turned back to see Resident #1 on his/her knees on the floor between the bed and the wall. CNA A went immediately and informed Registered Nurse (RN) B of the incident. CNA A said he/she did not know if RN B contacted the resident's representative or doctor. CNA A said it is part of the facility's policy for charge staff to notify a resident's family and doctor. During an interview on 06/03/25 at 3:05 P.M., CNA C said he/she assisted CNA A and RN B with transferring Resident #1 from the floor to the bed after he/she was found on the floor. CNA C said he/she did not know if RN B notified the resident's representative or doctor of the fall. During an interview on 06/03/25 at 12:40 P.M., the Director of Nursing (DON) said it is facility policy to contact a resident's family and doctor of an incident such as a fall. The DON said it would be the charge nurse's responsibility to make those notifications, assess the resident for injury and document all of that information in the record. The DON said, RN B failed to do any of those. The DON said she began an investigation when she heard about the situation. The Administrator held RN B's paycheck until RN B could come to the facility and place a late entry into the progress notes for Resident #1's medical record. Complaint # MO254482, MO254511